ASSEMBLY BILL No. 2839

Introduced by Assembly Member Huffman
(Principal coauthor: Assembly Member Krekorian)

February 22, 2008

An act to amend Section 1375.7 of the Health and Safety Code, and to amend Section 10133.65 of the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2839, as introduced, Huffman. Health Care Providers' Bill of Rights.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance and requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state. Existing law prohibits certain provisions in contracts between health care service plans or health insurers and health care providers.

This bill would prohibit a health care service plan health insurer from requiring a health care provider, or a consultant or attorney retained by a health care provider, to execute an unfair and unreasonable agreement as a condition of entering into contract negotiations with the plan or insurer, as specified. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner to, after appropriate notice and opportunity for a hearing, suspend or revoke the license of a health care service plan or the certificate of

authority of a health insurer or assess administrative penalties if the director or commissioner determines that the plan or insurer has violated those provisions.

Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1375.7 of the Health and Safety Code is amended to read:

1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:

(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However,

if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.

(C) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families program and compensates the provider on a fee-for-service basis, the contract may contain provisions permitting a material change to the contract by the plan, if the following requirements are met:

(i) The plan gives the provider a minimum of 90 business days' notice of its intent to change a material term of the contract.

(ii) The plan clearly gives the provider the right to exercise his or her intent to negotiate and agree to the change within 30 business days of the provider's receipt of the notice described in clause (i).

(iii) The plan clearly gives the provider the right to terminate the contract within 90 business days from the date of the provider's receipt of the notice described in clause (i) if the provider does not exercise the right to negotiate the change or no agreement is reached, as described in clause (ii).

(iv) The material change becomes effective 90 business days from the date of the notice described in clause (i) if the provider does not exercise his or her right to negotiate the change, as described in clause (ii), or to terminate the contract, as described in clause (iii).

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless

the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) (1) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(2) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 1395.6.

(B) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 1395.6.

(d) A plan shall not require a health care provider, or a consultant or attorney retained by a health care provider, to execute an unfair and unreasonable agreement as a condition of entering into contract negotiations with the plan. For purposes of this subdivision, an unfair and unreasonable agreement includes, but is not limited to, an agreement that does any of the following:

(1) Is presented on a "take it or leave it" basis with the threat that a health care provider failing to execute the agreement will not be permitted to negotiate a contract with the plan.

(2) Requires a health care provider to negotiate with a plan without professional or legal representation.

(3) Requires a health care provider to be present when its consultant or attorney engages in negotiations with a plan.

(4) Contains a definition of confidential information that is overboard, ambiguous, and without limit so that a health care provider, or its agents, consultants, or attorneys, are restrained from effective bargaining with the plan.

(5) Contains a restrictive provision on the consultants or attorneys of a health care provider that discourages those consultants or attorneys from representing the health care provider during negotiations with the plan.

(6) Does not impose any contractual obligations on the plan.

~~(d)~~

(e) Any contract provision that violates subdivision (b) or (c) shall be void, unlawful, and unenforceable.

(f) The director may, after appropriate notice and opportunity for a hearing, suspend or revoke the license issued to a plan or assess administrative penalties if the director determines that the plan has violated subdivision (d).

~~(e)~~

(g) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 into a report and submit the report to the Governor and the Legislature by March 15 of each calendar year.

~~(f)~~

(h) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

~~(g)~~

(i) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

SEC. 2. Section 10133.65 of the Insurance Code is amended to read:

10133.65. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a health insurer and a health care provider for the provision of covered benefits at alternative rates of payment to an insured shall contain any of the following terms:

(1) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(2) A requirement to comply with quality improvement or utilization management programs or procedures of a health insurer, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the health insurer may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to subdivision (c).

(3) A provision that waives or conflicts with any provision of the Insurance Code.

(4) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) If a contract is with a health insurer that negotiates and arranges for alternative rates of payment with the provider to provide benefits to insureds, the contract may contain provisions permitting a material change to the contract by the health insurer if the health insurer provides at least 45 business days' notice to the provider of the change, and the provider has the right to terminate the contract prior to implementation of the change.

(d) A health insurer shall not require a health care provider, or a consultant or attorney retained by a health care provider, to execute an unfair and unreasonable agreement as a condition of entering into contract negotiations with the health insurer. For purposes of this subdivision, an unfair and unreasonable agreement includes, but is not limited to, an agreement that does any of the following:

(1) Is presented on a "take it or leave it" basis with the threat that a health care provider failing to execute the agreement will not be permitted to negotiate a contract with the health insurer.

(2) Requires a health care provider to negotiate with a health insurer without professional or legal representation.

(3) Requires a health care provider to be present when its consultant or attorney engages in negotiations with a health insurer.

(4) Contains a definition of confidential information that is overboard, ambiguous, and without limit so that a health care provider, or its agents, consultants, or attorneys, are restrained from effective bargaining with the health insurer.

(5) Contains a restrictive provision on the consultants or attorneys of a health care provider that discourages those consultants or attorneys from representing the health care provider during negotiations with the health insurer.

(6) Does not impose any contractual obligations on the health insurer.

~~(d)~~

(e) Any contract provision that violates subdivision (b) or (c) shall be void, unlawful, and unenforceable.

(f) The commissioner may, after appropriate notice and opportunity for a hearing, suspend or revoke the certificate of authority issued to a health insurer or assess administrative penalties if the commissioner determines that the health insurer has violated subdivision (d).

~~(e)~~

(g) The Department of Insurance shall annually compile all provider complaints that it receives under this section, and shall report to the Legislature and the Governor the number and nature of those complaints by March 15 of each calendar year.

~~(f)~~

(h) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between health insurers and health care providers.

~~(g)~~

(i) For purposes of this section, the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization,

health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(2) "Health insurer" means any admitted insurer writing health insurance, as defined in Section 106, that enters into a contract with a provider to provide covered benefits at alternative rates of payment.

(3) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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